Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Family Planning Services

Program Guidelines & Billing Instructions

FAMILY
PLANNING
SERVICES

April 2000

Copyright Disclosure

About this publication

This publication supersedes all previous MAA Family Planning Services Billing Instructions.

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Washington State Department of Social and Health Services
April 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding it's programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out MAA's web site at:
http://maa.dshs.wa.gov

Write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

How do I obtain information regarding the Family Planning Program?

Check out the Family Planning page on MAA's web site at:
http://maa.dshs.wa.gov/familyplan/famplanindex.html

Who do I call if I have questions regarding…

Policy or program questions about family planning services?

Division of Program Support/
Family Planning
(360) 725-1652 or
(360) 725-1664

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Acquisition Cost - The cost of an item excluding shipping, handling, and any applicable taxes.

Categorically Needy Program - A federally matched program that provides maximum benefits to persons who qualify for Medical Assistance. Participation in this program will be indicated on the Medical Assistance IDentification (MAID) card with the ***CNP*** legend.

Client – An applicant for, or recipient of, DSHS medical care programs.

Client Support, Division of (DCS) - The division within the Washington State Medical Assistance Administration that is responsible for eligibility policy and administration of focused services for clients.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Offices (CSO) - An office of the department [that] administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department or DSHS - The Washington State Department of Social and Health Services.

Electronic Media Claims (EMC) - Medical claim data, client eligibility data, third-party insurance data and remittance data transmitted between Medical Assistance providers, or their intermediaries, and the MAA Division of Provider Services by means of personal computer, magnetic tape, mainframe computer, and/or the direct entry system.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Family Planning Services - Those medical care services related to planning the birth of children through the use of birth control methods, including sterilization.

Health Care Financing Administration Claim Form (HCFA-1500) – A claim form used to bill for Medicaid services.

Healthy Options - See Managed Health Care System.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.

(WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program [CNP] as defined in WAC 388-503-0310 and 388-511-1105 WAC; or
- Medically needy program [MNP] as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The administration within the department of social and health services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) cards – MAID cards are the forms the Department of Social and Health Services uses to identify clients of medical programs. . These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons. Clients receive a MAID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and that consists of:

a) First and middle initials (or a dash (-) if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha character (tie breaker).

Primary Care Case Management (PCCM) - One of the two managed care delivery models used in Washington State's Healthy Options program. Under this model primary care providers are paid a small monthly case management fee for each client enrolled with them. Services rendered are paid on a fee-for-service basis. The other model is capitation.

Primary Care Provider (PCP) - A physician who manages a Healthy Options client and acts as that client's primary contact for health care services. The primary care provider is responsible for providing care and/or referring the client to other medical providers (e.g., a specialist, durable medical equipment provider) for care, when necessary.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Remittance And Status Report - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

STD - Sexually-transmitted disease.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual & Customary Fee - This is the rate that may be billed to the department for a certain service or equipment. This rate *may not exceed:*

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Family Planning Program?

The Medical Assistance Administration (MAA) Family Planning Program provides family planning services and birth control methods to eligible clients. The purpose is to assist individuals in:

- Becoming and remaining self-sufficient; and
- Avoiding unintended pregnancy through planning and spacing the birth of their children.

Family Planning Services

What services are provided?

- **Physical Examination**

Annual physical exams are recommended for contraceptive-using clients. Female clients requesting birth control prescriptions should have a general physical exam at the initial visit and annually thereafter. This exam includes:

- Height and weight measurement
- Blood pressure measurement
- Thyroid palpation
- Heart and lung auscultation
- Breast exam, including self-exam instructions
- Abdominal palpation
- Extremities exam
- Complete pelvic exam (bimanual and speculum exam)
- Rectal exam, if necessary
- Urine pregnancy test
- Sexually Transmitted Diseases (STD) screening
- Lab tests
  - ✓ Hemoglobin (Hgb) or hematocrit (Hct)
  - ✓ Pap smear (yearly)

☞ **NOTE**: The Pap smear test may be waived if written results are available from a Pap smear done within the past six (6) months at another facility.

- **Medical History**

Obtain a comprehensive, personal history on all clients and pertinent, medical history of clients' immediate family members. Obtain this information at the initial, medical visit, and update it at subsequent visits.

- **<u>Information and Education about all Food and Drug Administration (FDA) Approved Birth Control Methods and STDs</u>**

  ✓ **Client Counseling**

  The primary purpose of family planning counseling is to help clients reach an informed decision regarding the choice and continued use of birth control methods and family planning services. The counseling process is designed to help clients resolve uncertainty, ambivalence, and anxiety about reproductive health and to allow them to make an informed decision.

  Providers <u>must:</u>

  - Counsel clients on all FDA-approved birth control methods and sterilization; and
  - Provide clients with any special counseling they need to make an informed decision.

  In addition, providers must give clients information on:

  - STD and HIV/AIDS transmission;
  - Personal STD risk and risk reduction;
  - Temporary and permanent birth control methods including sterilization and abstinence; and
  - Risks of pregnancy.

  ✓ **Client Education**

  Provide clients with the educational information they need to:

  - Understand the risks associated with unintended pregnancy and pregnancies spaced less than 24 months apart;
  - Make informed decisions about planning their pregnancies;
  - Use specific birth control methods; **and**
  - Understand the procedures involved in the family planning clinic visit.

  On an initial visit, offer clients information about basic female and male reproductive anatomy and physiology and teach the value of fertility regulation in maintaining individual and family health.

  Document in the client's record what information is provided. Additional education may also be provided on reproductive health and health promotion/disease prevention.

- ## Adolescent Client Services

Adolescent clients require skilled counseling and detailed information. Make appointments available to them for confidential counseling and medical services, even on short notice.

It is important ***not*** to assume that adolescents are sexually active simply because they request family planning services. Many teenagers are seeking assistance in reaching birth control decisions. Inform adolescents about the risks associated with pregnancy, including pregnancies spaced less than 24 months apart. Discuss abstinence as a valid and responsible option. Adolescents must be assured the sessions are confidential and that any follow-up will assure privacy. Encourage teenagers to discuss their needs with parents or other family members.

Adolescents seeking birth control must be informed about all FDA approved methods. As their needs frequently change, counseling should prepare them to use a variety of methods effectively. In addition, encourage teenagers and their parents to participate in the discussion together.

Because there is a high incidence of STDs among teenagers, it is essential to ask them about symptoms or possible exposure to infection. Urge teens at high risk of STD to undergo examination and treatment.

Providers should be sensitive to the possibility of sexual abuse in dealing with teens. Studies show the sexual abuse of teens may result in their early, continued sexual activity. Appropriate follow-up is essential when abuse is reported in a counseling session.

- ## Birth Control Methods

✓ All birth control methods must be available and discussed with clients. Birth control methods include:

- Norplant;
- Depo Provera injection;
- Condoms;
- Vaginal spermicidal products;
- IUD Copper T (10 year);
- IUD Progestasert (1 year);
- Birth control pills;
- Emergency contraception;
- Diaphragm;
- Cervical cap;
- Periodic abstinence;
- Female sterilization (tubal ligation); and
- Male sterilization (vasectomy).

✓ **Over The Counter Birth Control Supplies**

Make sure clients know they may use their MAID card to obtain the following birth control supplies at a pharmacy *without* a prescription:

- Male and female condoms; and
- Vaginal spermicidal products: cream, foam, film, gel, jelly, suppository with applicator, and refills as appropriate to the product

Future FDA approved birth control methods must also be provided and discussed.

Family Planning Services Extension

A woman whose medical care was paid by MAA during pregnancy is eligible for family planning services and supplies for an additional 10 months beyond the 60-day post pregnancy period.

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives a "Now Family Planning Services Available to You" flyer and a MAID card stating *FAMILY PLANNING ONLY*. If her pregnancy ends for any reason other than delivery, she must notify the CSO to receive the special MAID card.

The family planning services extension covers the same services, including sterilization, as the regular Family Planning program (see “What services are provided?”).

STD services are covered under the ***Family Planning Only*** program when the STD services are related to a birth control method (e.g., treating a chlamydia infection before inserting an IUD).

If the client becomes pregnant and requests an abortion, the ***Family Planning Only*** MAID card **does not** cover abortions. The client must return to the CSO and request a redetermination of her eligibility for full medical coverage.

NOTE: No other medical services are covered under the *Family Planning Only* MAID card.

Client Eligibility

Who is eligible?

Clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible for services under the Family Planning Program:

- **Children's Health**
- **CHIP** (Children's Health Insurance Program)
- **CNP** (Categorically Needy Program)
- **Detox** (Alcoholism and Drug Addiction Treatment and Support Act)
- **Family Planning Only**
- **GA-U No Out of State Care** (General Assistance-Unemployable)
- **LCP-MNP** (Limited Casualty Program-Medically Needy Program)

Who is not eligible?

EMER Hospital and No Out of State Care (Medically Indigent Program) – Clients presenting MAID cards with this identifier are not eligible for services under the Family Planning Program.

Can clients enrolled in managed care receive family planning services?

Healthy Options clients may self-refer outside their plan (HMO) or Primary care case manager (PCCM) for family planning services to a:

- Family planning provider who has a family planning provider number; or
- Pharmacy.

Send claims directly to MAA for self-referred services.

If a family planning provider does not have a contract with the client's managed care plan, the provider must obtain a family planning number from MAA to be reimbursed for family planning services.

NOTE: When a Healthy Options PCP or PCCM refers a client to your agency for family planning services (e.g., Norplant insertion), your agency **must bill the Healthy Options plan directly** for reimbursement for the family planning services.

Provider Requirements

How does a provider qualify to receive a family planning provider number?

To qualify as a family planning provider, a provider must:

1. Provide medical care services information and education about all FDA approved birth control methods, and over the counter birth control supplies to all eligible clients who desire such services. (See "What services are provided?")

2. Sign a special agreement that allows the provider to bill for family planning laboratory services provided through an independent laboratory certified through the Clinical Laboratory Improvements Act (CLIA).

   Laboratories bill their usual and customary charges. The family planning provider, in turn, must claim reimbursement from MAA for the lab fees. When reimbursed, the family planning provider pays the lab(s) only the amount reimbursed by MAA. (There is no need to pay other than what MAA reimbursed for lab fees.)

3. With client consent, establish a method or process to provide the client's primary care provider with information about the medical services provided.

The following services are not considered family planning:

- Infertility treatment services;
- Abortions;
- Menopausal treatment services;
- Cancer screenings; and
- All other reproductive health care services or primary care services and prenatal care services.

☞ **Note:** For billing services other than family planning and sexually-transmitted disease (STD) services, use your general medical MAA provider number (not your family planning clinic number) and bill using the RBRVS (Resource-Based Relative Value Scale) procedure codes (see below).

What if a provider has more than one provider number?

When your agency has more than one provider number, the following table outlines which number to use for billing Family Planning Services for self-referred Healthy Options and non-managed care fee-for-service (FFS) clients.

Type of Service	Self-Referred Healthy Options Clients	Family Planning Extension Clients	All Other Eligible Clients
Family Planning	Family Planning number	Family Planning number	Family Planning number
Sexually Transmitted Disease (STD)	Family Planning number	Family Planning number or Medical number	Family Planning number or Medical number
Abortion	Medical number	Not covered	Medical number
Other: menopause, preventive care, abnormal pap, precancerous conditions	Refer client to Primary Care Provider	Not covered	Medical number

Fee Schedule

Related codes are listed in your current Physician-Related Services Billing Instructions.

Procedure Code	Brief Description	July 1, 2002 Maximum Allowable Fee	
		Non-Facility Setting	Facility Setting
PRESCRIPTION BIRTH CONTROL METHODS			
Oral Contraceptives			
S4993	Contraceptive pills for birth control	$17.00	$17.00
1112J*	Emergency Contraceptive Pills (including Preven and Plan B)	Acquisition Cost	Acquisition Cost
Cervical Cap/Diaphragm			
9912M*	Diaphragm	45.00	45.00
A4261	Cervical cap for contraceptive use	47.00	47.00
57170	Fitting of diaphragm/cap	55.74	30.26
Implant			
A4260	Levonorgestrel (Norplant) implant system, including implant and supplies. ***One allowed in a 5-year period.***	451.68	451.68
11975	Insert contraceptive capsule	93.67	93.67
11976	Removal of contraceptive capsule	119.95	119.95
11977	Removal/Insert contra capsule	213.62	213.62

*State-unique procedure code

Procedure Code	Brief Description	July 1, 2002 Maximum Allowable Fee	
		Non-Facility Setting	Facility Setting
Injectables			
J1055	Injection, medroxyprogesterone acetate (Depo-Provera). ***Allowed once every 67 days.***	$49.99	$49.99
J1056	Injection, medroxyprogesterone acetate/estradiol cypionate (Lunelle). ***Allowed once every 23 days.***	24.02	24.02
Intrauterine Devices (IUD)			
J7300	Intrauterine copper device (Paragard)	280.00	280.00
S4989	Intrauterine device (non-copper) (Progestacert)	116.31	116.31
J7302	Levonorgestrel-releasing IUD (Mirena)	355.50	355.50
58300	Insertion of IUD	57.10	33.67
58301	Removal of IUD	68.25	42.54
NON-PRESCRIPTION OVER-THE-COUNTER (OTC) BIRTH CONTROL METHODS			
0391M*	Condoms, contraceptive foam, gel, jelly, film, cream, and suppositories. ***OTC products listed may not be available for billing MAA due to federal approval status.***	Acquisition Cost	Acquisition Cost
AIDS COUNSELING SERVICES			
9020M*	Risk factor reduction intervention for HIV/AIDS clients	27.63	27.63

*State-unique procedure code

Billing

What is the time limit for billing?

State law requires that you present your final charges to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days after you provide a service(s).
- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.
- **MAA will not pay if:**
  - ✓ The service or product is not covered by MAA; or
  - ✓ MAA is not billed within the time limit indicated above.

If you have questions about billing, please call 1-800-562-6188 for information or training.

Third-Party Liability

If a client has third-party insurance, the Family Planning provider **submits the claim for family planning services directly to MAA.** MAA arranges for third-party reimbursement.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill MAA for those services.

What must I keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide.

- **Chart** means a written summary of a nursing or medical evaluation on care given to an individual patient.
- **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service must be in chronological order by the practitioner who rendered the service.

For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. List of all birth control methods discussed with client.
8. Notes on discussion of emergency contraception, if appropriate.
9. Client plan – What birth control method will be used. If none, why not?
10. Medications, equipment, and/or supplies prescribed or provided.
11. Plan of treatment/care/outcome.
12. Recommendations for additional treatments, procedures, or consultations.
13. X-rays, laboratory, tests, and results.
14. Assessment of client's health status based on subjective and objective data.
15. Referrals to and from primary care providers (PCPs).
16. A release form signed by the client authorizing release of information for referral purposes, as necessary.

Charts/records must be available to DSHS or its contractor(s) and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

NOTE: Please see the *Family Planning Services* section for specific information about required documentation.

Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

☞ **Note:** MAA does not reimburse for hysterectomies performed solely for the purpose of sterilization. Refer to MAA's Physician-Related Services Billing Instructions for information on hysterectomies.

What are MAA's reimbursement requirements for sterilizations? [Refer to WAC 388-531-1550(2)]

MAA covers sterilization when all of the following apply:

- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual;
- The client has **voluntarily** given informed consent in accordance with all of the requirements explained under this section as required by CFR 441.258; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

☞ **Note:** MAA reimburses providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system.

MAA reimburses providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for the sterilization procedure only when a completed, federally approved Sterilization Consent Form is attached to the claim. MAA reimburses after the procedure is completed.

MAA reimburses providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. MAA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and

- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Additional Requirements for Sterilization of Mentally Incompetent or Institutionalized Clients

Providers must meet the following additional consent requirements before MAA will reimburse the provider for the sterilization of a mentally incompetent or institutionalized client. MAA requires both of the following to be attached to the claim form:

- A court order; and
- A Sterilization Consent Form signed by the legal guardian.

When does MAA waive the 30-day waiting period?

[WAC 388-531-1550(3)(4)]

MAA waives the 30-day waiting period, **but does require** at least a 72-hour waiting period, for sterilization in the following circumstances:

- At the time of premature delivery, the client gave consent at least 30 days before the *expected* date of delivery. The expected date of delivery must be documented on the consent form.
- For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

MAA waives the 30-day waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, **and** completes a sterilization consent form when one of the following circumstances apply:

- The client became eligible for Medical Assistance during the last month of pregnancy *("NOT ELIGIBLE 30 DAYS BEFORE DELIVERY");* or
- The client did not obtain medical care until the last month of pregnancy *("NO MEDICAL CARE 30 DAYS BEFORE DELIVERY"*); or
- The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery. *("NO SUBSTANCE ABUSE AT TIME OF DELIVERY.")*

The provider must note on the HCFA-1500 claim form in field 19 or on the backup documentation, which of the above waiver conditions has been met. Required language is shown in parenthesis. Electronic billers must indicate this information in the *Comments* field.

When does MAA not accept a signed Sterilization Consent Form? [Refer to WAC 388-531-1550(5)(6)]

MAA does not accept a signed Sterilization Consent Form obtained when the client is in any of the following conditions:

- In labor or childbirth;
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the client's state of awareness.

Why do I need a DSHS-approved Sterilization Consent Form?

Federal regulations prohibit payment for sterilization procedures until a federally approved and accurately completed Sterilization Consent Form is received. To comply with this requirement, surgeons, anesthesiologists, and assistant surgeons as well as the facility in which the surgery is being performed must obtain a copy of a completed Sterilization Consent Form to attach to their claim. **No other form will be accepted**.

MAA will deny a claim for a sterilization procedure received without a Sterilization Consent Form.

MAA will deny a claim with an incomplete or improperly completed Sterilization Consent Form. The claim and completed Sterilization Consent Form are to be submitted to the:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

Who completes the Sterilization Consent Form?

- Sections I, II, and III of the Sterilization Consent Form are completed by the client, interpreter (if needed), and the physician/clinic representative more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page 18b: "When does MAA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
- The bottom right portion (section IV) of the Sterilization Consent Form is completed on or after the surgery date by the physician who performed the surgery.

How to Complete the Sterilization Consent Form

- All information on the Sterilization Consent Form must be legible.
- All blanks on the Sterilization Consent Form must be completed *except* race, ethnicity, and interpreter's statement (unless needed).
- MAA does not accept "stamped" or electronic signatures.

The following numbers correspond to those listed on the Sterilization Consent Form:

Section I: Consent to Sterilization	
Item	**Instructions**
1. Physician or Clinic:	**Must be name of physician or clinic that gave client required information regarding sterilization.** This may be different than performing physician if another physician takes over.
2. Specify type of operation:	**Indicate type of sterilization procedure.**
3. Month/Day/Year:	Must be client's birth date.
4. Individual to be sterilized:	Must be client's name and match Items #7, #12, and #18 on Sterilization Consent Form.
5. Physician:	Must be name of physician who will perform sterilization. Physician who performs surgery must be same physician who signs on bottom right (see #22) of Sterilization Consent Form. If a different physician performs the surgery, he/she must complete Item #22 and attach a completed Client Statement Form (see page 20c).
6. Specify type of operation:	Indicate type of sterilization procedure.
7. Signature:	Client signature. Must be client's first and last name. Must match name on Items #4, #12, and #18 on Sterilization Consent Form. Must be original signature in ink.
8. Month/Day/Year:	Date of consent. Must be date that client signed Sterilization Consent Form. Must be more than 30 days, but less than 180 days, prior to date of sterilization. If less than 30 days, refer to page 18b: "When does MAA waive the 30 day waiting period?" and/or section IV of Sterilization Consent Form.

Section II: Interpreter's Statement	
Item	**Instructions**
9. Language:	**Must specify language into which sterilization information statement has been translated.**
10. Interpreter:	Must be interpreter's name. **Must be original signature in ink.**
11. Date:	Must be date of interpreter's statement.

Section III: Statement of Person Obtaining Consent	
Item	**Instructions**
12. Name of individual:	Must be client's first and last name. Must match client's name on Items #4, #7, and #18 on Sterilization Consent Form.
13. Specify type of operation:	Indicate type of sterilization procedure.
14. Signature of person obtaining consent:	Must be original signature in ink.
15. Date:	Date consent was obtained.
16. Facility:	Must be full name of clinic or physician obtaining consent. **Initials will not be accepted.**
17. Address:	Must be physical address of physician's clinic or office obtaining consent.

Section IV: Physician's Statement	
Item	**Instructions**
18. Name of individual to be sterilized:	Must be client's first and last name. Must match client's name on Items #4, #7, and #12 on Sterilization Consent Form.
19. Date of sterilization:	Must be more than 30 days, but less than 180 days, from client's signed consent date listed in Item #8. If less than 30 days, refer to page 18b: "When does MAA waive the 30 day waiting period?" and/or section IV of the Sterilization Consent Form.
20. Specify type of operation:	Indicate type of sterilization procedure.
21. Expected date of delivery:	When premature delivery box is checked, this date must be *expected* date of delivery. Do not use actual date of delivery.
22. Physician:	Physician's signature. Must be physician who actually performed sterilization procedure. Must be original signature in ink.
23. Date:	Date of physician's signature. Must be completed with either same date as listed in Item #19 or later. **NO EXCEPTIONS!**
24. Physician's printed name	Must be printed name of physician who signed in Item #22.

Note: If the physician who performs the surgery is different from the physician identified in Item #5, then a Client Statement Form must be attached to the Sterilization Consent Form. See "How to Complete a Client Statement Form."

How to Complete a Client Statement Form

When do I need a Client Statement Form?

- When the physician who performs the surgery is different from the physician identified in Item # 5; or
- When there is a change in the sterilization method.

General Guidelines

- All information must be legible.
- The Client Statement Form **must** be attached to the Sterilization Consent Form and submitted with each claim.
- The physician who performs the surgery must fill out items 18-24 on the Sterilization Consent Form.
- All blanks must be completed.

The following numbers correspond to those listed on the Client Statement Form:

Client Statement Form	
Item	**Instructions**
1. Individual to be sterilized:	Must be client's first and last name.
2. Physician:	Must be name of physician who actually performed sterilization. Must be same physician who signs Item #22 on Sterilization Consent Form.
3. Specify type of operation:	Indicate type of sterilization procedure.
4. Signature:	Client signature. Must be client's first and last name. Must match name on Items #4, #12, and #18 on Sterilization Consent Form. Must be original signature in ink.
5. Month/Day/Year:	Must be date that client signed Client Statement Form.

How to Complete a Sterilization Consent Form For a Client Age 18-20

1. Use DSHS 13-364(x) Sterilization Consent Form.
2. Cross out "**age 21**" in the following three places on the form and write in "**18**":

    a. Section I: Consent to Sterilization: **"I am at least 21…"**
    b. Section III: Statement of Person Obtaining Consent: **"To the best of my knowledge… is at least 21…"**
    c. Section IV: Physician's Statement: **"To the best of my knowledge… is at least 21…"**

Washington State Department of Social & Health Services

STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) _____
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) _____ The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) _____
Month Day Year

I (4) _____ hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) _____
Physician

by a method called (6) _____ My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the

consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) _____ signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) _____ the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) _____
Signature of person obtaining consent *Date*

(16) _____
Facility

(17) _____
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) _____ (19) _____
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) _____ The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) _____
Physician's Signature *Date*

(24) _____
Physician's Printed Name

SAMPLE STERILIZATION CONSENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

CLIENT STATEMENT

I (1) _____ hereby consent of my own free will to be sterilized by (2) _____
Individual to be sterilized *Physician*

by a method called (3) _____ My consent expires 180 days from the date of my signature below. I
Specify type of operation

also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(4) _____ (5) _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ White (not of Hispanic origin)

☐ Asian or Pacific Islander ☐ Hispanic

INTERPRETER'S STATEMENT (To be used if an interpreter is provided to assist the individual to be sterilized.)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to
Language
him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

SAMPLE STERILIZATION CONSENT FORM NEEDING CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least 21 years of age and was born on (3) **August 1, 1971**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☒ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2002**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2002**
Physician's Signature *Date*

(24) **Mary Williams**
Physician's Printed Name

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

SAMPLE CLIENT STATEMENT FORM

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

CLIENT STATEMENT

I (1) **Jane Doe** *Individual to be sterilized* hereby consent of my own free will to be sterilized by (2) **Dr. Mary Williams** *Physician*

by a method called (3) **tubal ligation** *Specify type of operation* My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funding by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(4) _____ *Signature* (5) **October 1, 2001** *Month Day Year*

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☒ American Indian or Alaska Native ☐ Black (not of Hispanic origin) ☐ White (not of Hispanic origin)

☐ Asian or Pacific Islander ☐ Hispanic

INTERPRETER'S STATEMENT (To be used if an interpreter is provided to assist the individual to be sterilized.)

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in **Spanish** *Language* language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ *Interpreter* **October 1, 2001** *Date*

STERILIZATION CONSENT FORM FOR A CLIENT 18 TO 20 YEARS OF AGE

NOTE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.

SECTION I: CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

(1) **Dr. Tim Lu**
Physician or Clinic

When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized . If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Aid to Families with Dependent Children (AFDC) or Medicaid, that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children, or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a

(2) **tubal ligation** The discomforts, risks, and
Specify type of operation

benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally-funded programs.

I am at least ~~21~~ 18 years of age and was born on (3) **August 1, 1984**
Month Day Year

I (4) **Jane Doe** hereby consent of my own
Individual to be sterilized

free will to be sterilized by (5) **Dr. Tim Lu**
Physician

by a method called (6) **tubal ligation** My consent
Specify type of operation

expires 180 days from the date of my signature below.
I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services; or
- Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) **August 20, 2001**
Signature *Month Day Year*

You are requested to supply the following information, but it is not required.
Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☒ Asian or Pacific Islander
- ☐ White (not of Hispanic origin)

SECTION II: INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained
Language

its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ (11) _____
Interpreter *Date*

SECTION III: STATEMENT OF PERSON OBTAINING CONSENT

Before (12) **Jane Doe** signed the consent form, I
Name of individual

explained to him/her the nature of the sterilization operation,

(13) **tubal ligation** the fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least ~~21~~ 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) **August 20, 2001**
Signature of person obtaining consent *Date*

(16) **US Clinic**
Facility

(17) **PO Box 123, Anywhere, WA 98000**
Address

SECTION IV: PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

(18) **Jane Doe** (19) **October 1, 2001**
Name of individual to be sterilized *Date of sterilization operation*

I explained to him/her the nature of the sterilization operation

(20) **tubal ligation** The fact that it is intended to be
Specify type of operation

a final and irreversible procedure; and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least ~~21~~ 18 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less that 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty (30) days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than thirty (30) days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested.)

- ☐ Premature delivery
  Individual's expected date of delivery (21) _____
- ☐ Emergency abdominal surgery (describe circumstances)

(22) _____ (23) **October 1, 2001**
Physician's Signature *Date*

(24) **Dr. Tim Lu**
Physician's Printed Name

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing MAA. (The numbered boxes on the claim form are referred to as ***fields***.) Use the instructions below to fill out the HCFA-1500 form. **Please enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

Do Not Write, Print, or Staple Any Attachments In The Bar Area at the Top of the Form.

Field **Description**

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card and consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d) An alpha or numeric character (tiebreaker)

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

NOTE: The MAID card is your proof of eligibility.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d*.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number Of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

19. **Reserved For Local Use**: When applicable, enter indicator **B**, *Baby on Parent's PIC*, or other comments necessary to process the claim.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., , April 12, 2000 = 041200).

24B. **Place of Service**: Required. These are the only appropriate code(s) for Washington State Medicaid:

Code	To Be Used For
1	Inpatient hospital
2	Outpatient hospital
3	Office or ambulatory surgery center
4	Client's residence
5	Emergency room
6	Congregate care facility
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

24K. **Reserved for Local Use**: Enter the laboratory's independent Clinical Laboratory Improvements Act (CLIA) number (see the information on your special agreement). Use this only when you are billing for a referred lab (test). Electronic billers must put the CLIA number in the comments field.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.:
This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Group:

This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, family planning, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

Sample:

Jennifer Spear was seen at ABC Family Planning Clinic (MAA Family Planning Provider # 7777777) on 4/12/00. She received a Physical Exam (99203) which included a Pap Test (88150). An STD was suspected, so a Wet Mount (87210) was done. Birth control options were discussed, a Pregnancy Test (84703) was done, and the client received a 6-month supply of Oral Contraceptives - Birth Control Pills (0390M)

The Pap Test was sent out to an independent lab (CLIA #06E3333333). They billed the clinic their usual and customary charge of $10.00. The Wet Mount and Pregnancy Test were read on-site at the clinic.

The following is a sample claim for the services this client received, including billing for the test done at the independent lab.

Sample HCFA-1500 Claim Form

(Not available on Internet)

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